



Environmental Protection Agency PRE / POST DEPLOYMENT EVALUATION

Medical Evaluation Form

Privacy Act Statement

The collection and use of this information is authorized by 5 U.S.C. 7901 (Health Services Programs) and 20 U.S.C 657 (Occupational Health and Safety; Record Keeping). The information will become part of your official Employee Medical File, and will be used to assist Federal Occupational Health in carrying out its occupational health services responsibilities under one or more interagency agreements with our employee agency, and for other official purposes and routine uses as described in Privacy Act systems notice OPM/GOVT-10 (Employee Medical File System Records). Providing the requested information is voluntary. Not providing the information may affect the availability and quality of health services rendered to you, and may also affect the completeness of information used by your agency in making determinations of medically-related employment decisions.

**Use ONLY for EPA Employees not currently in a Medical Surveillance Program
who are Deployed to Disaster Impact Zone**





PRE / POST DEPLOYMENT Medical Evaluation Form

Use ONLY for EPA Employees Deployed to Disaster Impact Zone



Purpose of Pre/Post-Deployment Evaluation

The Pre/Post-Deployment Evaluation targets EPA employees not currently enrolled in an appropriate medical surveillance program AND who may be exposed to hazardous conditions during disaster response efforts. These employees should undergo, as soon as feasible, basic screening to document current health status, work activities or conditions, and work-related illness or injury. Workers who report repeated or prolonged hazardous exposures, injuries, symptoms or, for whom specific risk factors are identified, shall receive more comprehensive screening directed at risk factors, exposures, or adverse health effects encountered. *This is not a respirator medical evaluation.*


How Does This Work?

• **Pre-Deployment Evaluation**

Pre-deployment assessment is designed to update employee immunizations, identify key health problems (that might complicate deployment), and collect baseline health information for comparison post-deployment.

- EPA will distribute this form and provide a list of employees designated for deployment to FOH. Pre-deployment appointments will take ~30 minutes and can be scheduled by the employee at the designated Health Centers.

• **What makes up the Pre-Deployment Evaluation** There are 3-steps:

- Step. #1 Employees should complete the form (*Pages 3-9*) prior to their scheduled appointment. Employee sections are color coded  and clearly marked ("*EPA employee to complete*"). Using a computer to complete the form will reduce errors, improve legibility, and allow duplicate fields to be populated automatically throughout the form.
- Step #2. FOH nurse records vital signs, administers immunizations, and conducts indicated procedures.
- Step #3 In Health units with a Physician or NP, the practitioner reviews employee medical history and documents concerns or contraindications for deployment. The Physician or NP should complete the **BLACK** sections entitled "*Pre-Deployment Evaluation*" (*Page 4*), "*Pre-Deployment Clearance*" (*Page 10*), and any positive employee responses noted in the "*Medical History*" (*Pages 5-8*).

In Health units without a Physician or NP, the RN in the health unit will review form for completion of employee responses and forward completed form to the Medical Reviewing Officer (RMO). The RMO will document concerns for contraindications for deployment. The RMO should complete the **BLACK** sections entitled "*Pre-Deployment Evaluation*" (*Page 4*), "*Pre-Deployment Clearance*" (*Page 10*), and any positive employee responses noted in the "*Medical History*" (*Pages 5-8*).

• **Record keeping**

- In health units with Physicians or NPs, employees will be given a signed copy of their recommendation (*Page 9*) at the end of their appointment. The original **Pre-Deployment Form** (*Pages 3-10*) is placed in the medical record and a copy faxed to Joe Lima at 617-565-1471. Joe Lima will notify SEMP Managers of recommendations.
- In health units without Physicians or NPs, the original **Pre-Deployment Form** (*Pages 3-10*) is placed in the medical record and a copy faxed to Joe Lima at 617-565-1471. Joe Lima will forward information to the RMO. Joe Lima will notify SEMP Managers and health units of recommendations.
- Employees are also given the **Post-Deployment Form** (*Pages 11-14*). This form is used by the employee to document exposures during their deployment. Employee updates the Deployment Exposure History (*Page 12*) during his/her deployment. Once employee returns to home station, the employee should complete the Post-Deployment Form (*Pages 11-14*) and fax it to Joe Lima at 617-565-1471. The employee should save a copy for personal records.

HEALTH CENTER STAMP

Pre-Deployment Medical Evaluation Form

Use ONLY for EPA Employees Deployed to Disaster Impact Zone

① DEMOGRAPHIC DATA *(EPA Employee to complete)*

Name (Last, First):		Date of Birth:	SS# (### - ## - #####):	Sex (M / F):	Work Phone (### - ### - #####):
Street Address:		Supervisor Name:			Supervisor Phone (##### - ### - #####):
City:	State:	SHEMP Manager:			SHEMP Manager Phone (### - ### - #####):
Position Title:		Which of these Workgroups do you belong:			
Div. / Br. / Sec.		<input type="checkbox"/> IMT (Incident Management Team) / Field Office Staff		<input type="checkbox"/> Field Observer	
		<input type="checkbox"/> Public Relations / Community Involvement		<input type="checkbox"/> Other _____	

② PRE-DEPLOYMENT EVALUATION *(FOH Nurse to complete)*

<input type="checkbox"/> Review of History (Pages 5-8) – Nurse should comment on all employee positive responses																																								
<input type="checkbox"/>	Vital Signs Ht _____ Wt. _____ BP _____ Pulse _____ Resp. _____		Repeat BP (if needed): _____ Date: _____ Repeat BP (if needed): _____ Date: _____		Nurse Comments:																																			
	Immunization (Vaccinations needed for this deployment) Td if >10 yr <i>(recommended)</i> Hepatitis A <i>(optional)</i> Hepatitis B <i>(optional)</i>		<i>(circle one)</i> <input type="checkbox"/> Td Given Date: _____ <input type="checkbox"/> Hepatitis A # ❶ # ❷ Date: _____ <input type="checkbox"/> Hepatitis B # ❶ # ❷ # ❸ Date: _____		<input type="checkbox"/> Hep. A # ❷ Date: _____ <input type="checkbox"/> Hep. B # ❷ # ❸ Date: _____																																			
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> If Indicated Services <i>(Check only if done. Complete test if employee meets indicated criteria)</i> <input type="checkbox"/> Spirometry <i>(indicated if employee has adult asthma, SOB, or COPD)</i> <input type="checkbox"/> Chest X-ray <i>(indicated if SOB, chest pain, or positive respiratory history)</i> <input type="checkbox"/> EKG <i>(indicated if SOB, chest pain, or positive cardiac history)</i> <input type="checkbox"/> FOH Panel <i>(indicated if positive history of metabolic disease (e.g., diabetes))</i> </div> <div style="width: 38%;"> Results of Indicated Services <i>(Check when completed)</i> <i>Abnormal results must be reviewed by Medical Reviewer</i> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Spirometry:</td> <td style="width: 15%;">FVC</td> <td style="width: 15%;">FEV 1</td> <td style="width: 15%;">FEV1/FVC</td> <td style="width: 15%;">FEF25-75</td> </tr> <tr> <td>Actual in liters</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>% Predicted</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Spirometry Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td colspan="5">Chest X-ray Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td colspan="5">EKG Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td colspan="5">FOH Panel: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> </table> </div> </div>						Spirometry:	FVC	FEV 1	FEV1/FVC	FEF25-75	Actual in liters					% Predicted					Spirometry Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal					Chest X-ray Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal					EKG Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal					FOH Panel: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
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③ SOCIAL HISTORY *(EPA Employee to complete)*

Employee Last Name: _____

Pre-Deployment Medical Evaluation Form

Use ONLY for EPA Employees Deployed to Disaster Impact Zone

Smoking History

Smoking increases your risk for lung cancer and other types of cancer, bronchitis, emphysema, asbestos-related lung diseases, coronary heart disease, high blood pressure, and stroke. (Check All that apply.)

☐ Never Smoked

☐ Current / Former Smoker

Are you still smoking?

☐ Yes

☐ No

of cigarettes per day

_____ pks/day

of cigars per day

of Pipe bowls per day

Total years smoked

of years since you quit

_____ (Former smokers only)

Nurse Smoking Comments (Optional):

Alcohol/Drug Use (Complete question and check all that apply)

What is your average alcohol use? _____ drinks per week

(1 drink = 12 oz beer, 1 glass wine, or 1.5 oz liquor)

How often do you drink alcohol?

☐ Weekdays

☐ Weekends

☐ Both

Do you use recreational drugs?

☐ Currently

☐ Previously

☐ Never

Nurse Alcohol/Drug Comments (Optional):

④ MEDICATION / ALLERGIES / HOSPITALIZATIONS (EPA Employee to complete)

List Current Medications:

List Current Medication Allergies:

List Hospitalization in the
last two years:

⑤ MEDICAL HISTORY (EPA Employee to complete)

Vision

Yes

No

Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work

Pre-Deployment Medical Evaluation Form

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			<i>limitations</i>
Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Vision Comments (Required on all positives) <i>Are headaches so frequent or severe that the employee has to limit activity? Do they disrupt vision so the employee could not drive or operate machinery safely? Does the employee know what disease he has or what is causing the problem? Is it mild, moderate, or severe? Does it prevent him/her from doing routine activities safely (e.g., driving, reading in low light, reading traffic lights)? Are there any residual complications from past eye surgery (halos, can't drive at night, etc.)?</i>
Unexplained blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Known eye disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	
Colorblindness?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear eye glasses?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear contacts	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had surgery to correct nearsightedness?	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	Yes	No	<i>Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.</i>
Ringing in ear?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Comments (Required on all positives) <i>Does the employee's problem prevent him from hearing a telephone or warning ("Hey, watch out!")? Hearing aid used? Describe dizziness or balance problems. When does it occur, what brings it on, and how bad is it (does it cause the employee to stop what he/she is doing?) Is there anything that would keep the employee from flying or diving (ear infection?). Is the employee currently exposed to noise hazards at home or work? Is protection used (25%, 50%, 75%, or 100% of the time)?</i>
Difficulty hearing?	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness / Balance problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Current ear infection / cold?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you in a hearing conservation program?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use hearing protection?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart / Cardiovascular	Yes	No	<i>Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations</i>
Angina (heart pain)?	<input type="checkbox"/>	<input type="checkbox"/>	Heart/Cardiovascular Comments (Required on all positives) <i>Angina / Palpitations: What causes it to occur? What t relieves it? How often does it occur? Does it cause SOB / dizziness / loss of consciousness? Heart Attack: When did it occur? Treatment? Last EST? Limits on exercise or work restriction? Heart Disease: Blood thinners?</i>
Irreg. heart beat / palpitations?	<input type="checkbox"/>	<input type="checkbox"/>	
History of heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	
Organic heart disease (prosthetic heart valves, heart block, pacemaker, etc.) ?	<input type="checkbox"/>	<input type="checkbox"/>	
Past heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	

Employee Last Name: _____

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⑤ MEDICAL HISTORY (EPA Employee to complete)			
Lungs / Respiratory	Yes	No	<i>Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.</i>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Lung / Respiratory Comments (Required on all positives) <i>Is the employee's asthma well controlled? When was last hospitalization due to asthma? When was last attack? What triggers attacks? How often does employee use an inhaler? Sinus Infection: When did employee have last infection? How was it treated? Any residual or exposures their physician has advised them to avoid? TB: When diagnosed? How treated? Did they complete treatment? Any current Symptoms?</i>
Bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	
Acute / Chronic lung infection?	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic sinusitis / rhinitis?	<input type="checkbox"/>	<input type="checkbox"/>	
Collapsed lung?	<input type="checkbox"/>	<input type="checkbox"/>	
Scoliosis (curved spine) with breathing limitations?	<input type="checkbox"/>	<input type="checkbox"/>	
History of tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	
Vascular	Yes	No	<i>Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.</i>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Comments (Required on all positives) <i>HTN: When diagnosed? On medication? Does he/she take her medication? Is blood pressure well controlled? Varicose Veins: History of blood clots? Leg pain? White Finger? When diagnosed? How often does this occur? How do they control or prevent it? What triggers it (cold, vibrating equipment, etc.? CVA/TIA: When it occurred? How treated? Describe residual impairments and limitations (weakness left leg can't climb ladder/drive car without modifications)?</i>
Varicose Veins?	<input type="checkbox"/>	<input type="checkbox"/>	
Poor circulation hands/feet?	<input type="checkbox"/>	<input type="checkbox"/>	
White finger (cold/vibration)	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke / TIA?	<input type="checkbox"/>	<input type="checkbox"/>	
Aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	Yes	No	<i>Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.</i>
Amputations?	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Comments (Required on all positives) <i>If they lost limb, what can't they do (e.g., jump, climb, task that require good balance, etc). Chronic conditions should be described as mild, moderate, or severe. Does it prevent the employee from doing any "recreational" or "work" activity? Are there any current activity limitations from the employee's physician?</i>
Loss of use of arm/leg/hand?	<input type="checkbox"/>	<input type="checkbox"/>	
Moderate to severe arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	
Moderate to severe tendonitis?	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic back pain if associated with pain radiating down leg or leg weakness?	<input type="checkbox"/>	<input type="checkbox"/>	
Unstable shoulder / knee/ankle?	<input type="checkbox"/>	<input type="checkbox"/>	

Employee Last Name: _____

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⑤ MEDICAL HISTORY (EPA Employee to complete)

Gastrointestinal	Yes	No	Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations
Hiatal hernia / Severe reflux?	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Comments (Required on all positives) <i>For deployments diets cannot be generally well controlled. Employees who need to maintain a strict control of their diet because of their medical condition may not be candidates for deployment. Reflux: Is the condition stable or uncontrolled? Hernia: Type? Has it been repaired? Is there a lifting restriction? Bleeding: What caused it? Is it corrected? Last episode? Dizziness/loss of consciousness?</i>
Diverticulitis?	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
Colostomy?	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding (Rectal / Vomiting)?	<input type="checkbox"/>	<input type="checkbox"/>	
Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel obstruction?	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	Yes	No	Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary Comments (Required on all positives) <i>For deployments, access to toilet facilities may not be readily available. Frequency and urgency should be discussed.</i>
Difficult or painful urination?	<input type="checkbox"/>	<input type="checkbox"/>	
Infertility (difficulty having children)?	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	Yes	No	Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Comments (Required on all positives) <i>Stress with long irregular work hours may exacerbate seizures or migraines. Sz: Type (grand mal?) How frequently to they occur? Triggers? Insomnia: Cause (situational, environmental, dietary (caffeine)? Has it been evaluated? Daytime sleepiness? Neurological Disease: What is it? When Diagnosed? Tx'ment? Any physical or mental deficits?</i>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble sleeping (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	
Head/Spine surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Any neurological disease	<input type="checkbox"/>	<input type="checkbox"/>	
Head trauma (persistent deficit)	<input type="checkbox"/>	<input type="checkbox"/>	

Employee Last Name: _____

Pre-Deployment Medical Evaluation Form

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⑤ MEDICAL HISTORY *(EPA Employee to complete)*

Psychiatric	Yes	No	<i>Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.</i>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Comments <i>(Required on all positives)</i> <i>Stress with long irregular work hours may exacerbate psychiatric conditions. Is condition well controlled? Last exacerbation? Triggers?</i>
Stress / Anxiety / Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Neurosis / Hysteria <i>(circle one)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Obsessive/Compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalized for psychiatric disease	<input type="checkbox"/>	<input type="checkbox"/>	
Taken medication for treat mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	

⑥ PHYSICAL & ENVIRONMENTAL HAZARD *(EPA Employee to complete)*

Have you experienced?	Nurse Physical/Environmental Hx Comments <i>(Required for all positives)</i>
<input type="checkbox"/> Latex Allergy <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Animal Protein Allergy <input type="checkbox"/> Back Problems <input type="checkbox"/> Hypothermia / Cold Injury <input type="checkbox"/> Mold/Mildew Allergy <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Hyperthermia / Heat Injury <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Vibration effects <input type="checkbox"/> Adverse Effects from Confined Space <input type="checkbox"/> Health Effects from Hazardous Waste	

⑦ PHYSICAL ACTIVITY / EXERCISE HISTORY (EPA Employee to complete)

Intensity (check one): ☐ Low ☐ Moderate

Activity Type: _____

Frequency: _____ days per week

Duration: _____ minutes per session

Pre-Deployment Medical Evaluation Form

Employee Comments (Optional)

Use ONLY for EPA Employees Deployed to Disaster Impact Zone

⑧ OCCUPATIONAL HISTORY (EPA Employee to complete)

Description of Duties in Current Job: _____

Functional Activities (Current position):

☐ Heavy Lifting (>40lbs) ☐ Walking ____ hrs/day ☐ Standing ____ hrs/day
☐ Climbing ☐ Operation of motor vehicle ☐ Crawling ☐ Diving

Usual Exposures (Current position):

Check all that apply

☐ Dust ☐ Fumes ☐ Pesticides ☐ Gases ☐ Radiation
☐ Asbestos ☐ Noise ☐ Vibrations ☐ Confined space ☐ Sewage
☐ Heavy metal ☐ Chemicals ☐ Temperature extremes

Previous Adverse Health Effects Possibly Related to the Job? (Describe):

Other Work Performed? (e.g., Moonlighting, hobbies, etc.):

Any Other Exposure to Hazardous Material? (Describe)

Work History:

How long have you been doing this type of work? _____ Years

Have you ever been off work more than a day because of work-related illness/injury (Check one)? ☐ No ☐ Yes If yes, describe:

Have you ever changed jobs or duties due to health problem? ☐ No ☐ Yes If yes, describe:

Pre-Deployment Medical Evaluation Form

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⑨ PRE-DEPLOYMENT CLEARANCE *(EPA Employee completes)*

Employee Name (Last, First):	SSN (### - ## - ####):	Position Title:	Work Phone (### - ### - ####):
Supervisor Name:	Supervisor Position Title:	Supervisor Phone (#### - ### - ####):	FOR FOH USE ONLY FOH Health Center <i>(Health Ctr. Stamp)</i>
	Div. / Br. / Sec.		
SHEMP Manager Name:	SHEMP Manager Phone (#### - ### - ####):	SHEMP Manager FAX (#### - ### - ####):	
SHEMP Manager Address (RM #, Street, City, State):			

NOTE: This clearance page is sent to your SHEMP Manager. Make sure your SHEMP Manager's Fax OR mailing address is included on this form.

Pre-Deployment Medical Clearance Statement *(FOH Nurse or Medical Reviewer completes)*

In my opinion, the above employee is:

- ☐ **CLEARED** for deployment as directed by standing orders *(Expires one year from review date)*
- ☐ **DEFERED.** Further evaluation, as described below, is needed before a deployment decision can be made.
- ☐ **NOT MEDICALLY QUALIFIED** for deployment
- ☐ **CLEARED WITH LIMITATIONS**

Recommended Limitations or Evaluation needed

The employer should call the Health Center (see above contact information) if they want to complete the recommended evaluation.

Nursing / Medical Provider Signature: _____

Review Date: _____

Printed Name: _____

Disaster Impact Zone Post-Deployment Medical Evaluation Form

Post-Deployment Form Starts Here

- Employee should use this portion of the form to track exposures during their deployment
- Once you return to your home base, complete any missing information and fax this post-deployment form to Joe Lima at 617-565-1471. Keep & file copy for your records.
 - Your record will be reviewed and filed for future reference.
 - If you developed significant problems during your deployment, you will receive a follow-up call.

Contact Information:

Joseph Lima
Account Manager Assistant
Federal Occupational Health
JFK Building, Room E-110
25 New Sudbury Street
Government Center
Boston, MA 02203
617-565-3062 (Voice)
617-565-1471 (Fax)

Disaster Impact Zone Post-Deployment Medical Evaluation Form

① DEMOGRAPHIC DATA *(EPA Employee to complete)*

Name (Last, First): _____		Date of Birth:	SS# (### - ## - #####):	Sex (M/F):	Work Phone (### - ### - #####):
Street Address:		Supervisor Name:			Supervisor Phone (#### - ### - #####):
City:	State:	SHEMP Manager:			SHEMP Manager Phone (### - ### - #####):
Position Title: _____		Which of these Workgroups do you belong:			
Div. / Br. / Sec.		<input type="checkbox"/> IMT (Incident Management Team) / Field Office Staff		<input type="checkbox"/> Field Observer	
		<input type="checkbox"/> Public Relations / Community Involvement		<input type="checkbox"/> Other _____	

② POST-DEPLOYMENT EXPOSURE HISTORY *(EPA Employee to complete)*

Use this form to track your duty assignments and possible exposure during your deployment. Make a copy of this page if you run out of room.

S A M P L E	Site: <i>(State / City / County / Site) if available include EPA Identifier #</i>	Date: <i># Days Inclusive dates onsite</i>	Specific Chemical and Physical Factors <i>Chemicals at site, if known</i>	Exposure Level <i>Low - High</i>	Level of PPE <i>Level A/B/C/D None</i>	Symptoms from Exposure	Job Duties
#1							
#2							
#3							
#4							
#5							

Disaster Impact Zone Post-Deployment Medical Evaluation Form

③ POST-DEPLOYMENT QUESTIONNAIRE *(EPA Employee to complete)*

<p>#1 Did your health change during this deployment?</p> <p style="margin-left: 40px;"> <input type="checkbox"/> Health stayed about the same <input type="checkbox"/> Health got worse </p>	<p>#6 Do you have any of these symptoms now, or did you develop them anytime during this deployment?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Chronic Cough</td> <td><input type="checkbox"/> Runny nose</td> <td><input type="checkbox"/> Difficulty breathing</td> </tr> <tr> <td><input type="checkbox"/> Fever</td> <td><input type="checkbox"/> Weakness</td> <td><input type="checkbox"/> Back pain</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Muscle aches</td> <td><input type="checkbox"/> Chest pain</td> </tr> <tr> <td><input type="checkbox"/> Rash/Skin disease</td> <td><input type="checkbox"/> Ringing in ears</td> <td><input type="checkbox"/> Still tired after sleeping</td> </tr> <tr> <td><input type="checkbox"/> Dimming of vision</td> <td><input type="checkbox"/> Dizziness/fainting</td> <td><input type="checkbox"/> Difficulty remembering</td> </tr> <tr> <td><input type="checkbox"/> Anger/Irritability</td> <td><input type="checkbox"/> Vomiting/Diarrhea</td> <td><input type="checkbox"/> Frequent indigestion</td> </tr> <tr> <td><input type="checkbox"/> Swollen stiff / painful joints</td> <td></td> <td><input type="checkbox"/> Numbness/tingling hands</td> </tr> </table>	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Fever	<input type="checkbox"/> Weakness	<input type="checkbox"/> Back pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rash/Skin disease	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Still tired after sleeping	<input type="checkbox"/> Dimming of vision	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Difficulty remembering	<input type="checkbox"/> Anger/Irritability	<input type="checkbox"/> Vomiting/Diarrhea	<input type="checkbox"/> Frequent indigestion	<input type="checkbox"/> Swollen stiff / painful joints		<input type="checkbox"/> Numbness/tingling hands
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<input type="checkbox"/> Headaches	<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Chest pain																				
<input type="checkbox"/> Rash/Skin disease	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Still tired after sleeping																				
<input type="checkbox"/> Dimming of vision	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Difficulty remembering																				
<input type="checkbox"/> Anger/Irritability	<input type="checkbox"/> Vomiting/Diarrhea	<input type="checkbox"/> Frequent indigestion																				
<input type="checkbox"/> Swollen stiff / painful joints		<input type="checkbox"/> Numbness/tingling hands																				
<p>#2 How many times were you seen for medical evaluation during this deployment?</p> <p style="margin-left: 40px;">_____ times</p>																						
<p>#3 Did you have to spend one or more nights in a hospital as a patient during this deployment?</p> <p style="margin-left: 40px;"> <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason / Dates </p>	<p>#7 During his deployment did you ever feel that you were in danger?</p> <p style="margin-left: 40px;"> <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason / Dates </p>																					
<p>#4 Did you receive any vaccinations just before or during this deployment?</p> <p style="margin-left: 40px;"> <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason / Date </p>	<p>#8 Are you currently interested in receiving help for stress, emotional alcohol or family problems?</p> <p style="margin-left: 40px;"> <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason / Dates </p>																					
<p>While you were deployed were you exposed to <i>(circle all that apply)</i> Y=Yes, N=No, NC=Not Certain:</p> <table style="width: 100%; border: none;"> <tr> <td>Y N NC Chemicals</td> <td>Y N NC Fatigue</td> </tr> <tr> <td>Y N NC Traumatic Incident Stress</td> <td>Y N NC PPE</td> </tr> <tr> <td>Y N NC Heat Stress</td> <td>Y N NC Solvents</td> </tr> <tr> <td>Y N NC Ultraviolet Radiation</td> <td>Y N NC Sand/dust</td> </tr> <tr> <td>Y N NC Petroleum Products</td> <td>Y N NC Dispersants</td> </tr> <tr> <td>Y N NC Odors</td> <td></td> </tr> </table>	Y N NC Chemicals	Y N NC Fatigue	Y N NC Traumatic Incident Stress	Y N NC PPE	Y N NC Heat Stress	Y N NC Solvents	Y N NC Ultraviolet Radiation	Y N NC Sand/dust	Y N NC Petroleum Products	Y N NC Dispersants	Y N NC Odors		<p>#9 Did you experience anything during this deployment that was so upsetting that you:</p> <p style="margin-left: 40px;"> <input type="checkbox"/> Are having nightmares? <input type="checkbox"/> Avoiding situations that remind you of it <input type="checkbox"/> Are constantly watchful or easily startled <input type="checkbox"/> Feel numb or detached from others. </p>									
Y N NC Chemicals	Y N NC Fatigue																					
Y N NC Traumatic Incident Stress	Y N NC PPE																					
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Y N NC Odors																						

Medical Reviewer Notes:

Disaster Impact Zone Post-Deployment Medical Evaluation Form

④ DEMOGRAPHIC DATA *(EPA Employee to complete)*

Employee Name (Last, First):	SSN (### - ## - ####):	Position Title:	Work Phone (### - ### - ####):
Supervisor Name:	Supervisor Position Title:	Supervisor Phone (#### - ### - ####):	FOR FOH USE ONLY FOH Health Center <i>(Health Ctr. Stamp)</i>
	Div. / Br. / Sec.		
SHEMP Manager Name:	SHEMP Manager Phone (#### - ### - ####):	SHEMP Manager FAX (#### - ### - ####):	
# of Disaster Deployments this year: <i>(Circle one)</i> #1 #2 #3 #4 #5	SHEMP Manager Address (Room #, Street, City, State):		

NOTE: This clearance page is sent to your SHEMP Manager. Make sure your SHEMP Manager's Fax OR mailing address is included on this form.

Post-Deployment Medical Referral *(FOH Nurse or Medical Reviewer completes)*

I have reviewed the Pre/Post-Deployment information provided by the above employee. As a result of this information:

- ☐ **NO ADDITIONAL Follow Up is needed.** Pre/Post-Deployment forms have been filed in the medical record.
- ☐ **REFERRAL IS NEEDED.** Further evaluation, as described below, is needed to evaluate a possible work-related exposure.
- ☐ **WORK LIMITATIONS ARE NEEDED.**

The following work limitations or referral is recommended:

The employer should call Wayne Grant at (816) 926-7700 if they need assistance if arranging the recommended evaluation.

Medical Reviewer Signature: _____

Review Date: _____

Printed Name: _____